2013 Health and Life Insurance Election Form
PARTICIPATING AGENCY Employees

PRIMARY INFORMATION – Please PRINT

Use this form for initial insurance enrollment or for an eligible qualifying event. **Additional paperwork may be required** (see Required Documentation and Dependent Eligibility document) and return to the OHR Insurance Team by the applicable deadline.

Employee ID: _____ Last 4 of SSN: _____

Name: _____

Street Address: _____

City, State, ZIP Code: _____

Telephone Home #: (_____) _____ – _____ Cell #: (_____) _____ – _____

Email Address: _____

*Your email address will not be shared and will **only be used by OHR** to contact you regarding your health insurance.*

Medical (choose one)

- ❑ No Medical coverage
- ❑ Kaiser HMO (includes Kaiser Rx)
- ❑ United HealthCare HMO
- ❑ CareFirst POS High Option
- ❑ CareFirst POS Standard Option

For eligible participants living outside the POS service area

- ❑ CareFirst POS High Opt. Out-of-Area (Medical Only)
- ❑ CareFirst POS Standard Opt. Out-of-Area (Medical Only)

Prescription / Rx (choose one)

For the Kaiser medical plan, no Rx election is needed.

- ❑ No Caremark Prescription coverage
- ❑ Caremark High Option Rx plan
- ❑ Caremark Standard Option Rx plan

Vision Plan (choose one)

- ❑ No Vision coverage (2-year waiting period to re-enroll)
- ❑ Vision Plan

Dental (choose one)

- ❑ No Dental Coverage (2-year waiting period to re-enroll)
- ❑ Dental PPO (traditional dental plan)
- ❑ Dental DHMO

Dependent Life (choose one)

- ❑ Cancel Dependent Life coverage
- ❑ $2,000 / $1,000 / $100
- ❑ $4,000 / $2,000 / $100
- ❑ $10,000 / $5,000 / $100

Optional Life (choose one)

To increase coverage, a Statement of Health may be

- ❑ Cancel Optional Life coverage
- ❑ 1x annual earnings
- ❑ 2x annual earnings
- ❑ 3x annual earnings
- ❑ 4x annual earnings

DEPENDENT COVERAGE – Please PRINT

To change dependent coverage, complete the section below and **include copies of the required documentation** (e.g., birth certificate, adoption certificate, marriage certificate, etc.). Note that you must elect the same coverage for yourself in the Medical, Rx, Dental and/or Vision sections of this form (e.g., your dependent may not have the vision plan unless you do).

❑ **Add Eligible Dependent(s)** ❑ **Keep Same Dependent Coverage**

SOCIAL SECURITY NUMBER	FULL NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	*RELATIONSHIP	INSURANCE ELECTIONS
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision

** please see the Required Documentation and Dependent Eligibility document*

❑ **Delete / Disenroll Dependent(s)**

SOCIAL SECURITY NUMBER	FULL NAME OF DEPENDENT	DATE OF BIRTH	COVERAGE TO BE CANCELLED
			❑ Medical ❑ Dental ❑ Rx ❑ Vision
			❑ Medical ❑ Dental ❑ Rx ❑ Vision
			❑ Medical ❑ Dental ❑ Rx ❑ Vision

SIGNATURE (must be signed to be effective)

I have read the materials available for the County's Group Insurance Program (Program). I authorize the County to make a payroll deduction for my benefit elections. If I pay directly for benefits insurance, I will promptly pay the cost or benefits will terminate. I understand that I can only change my elections during the year if I have a Status Change (see Summary Description). I also understand that the County may adjust my elections. I authorize the release of enrollment information to the extent necessary to properly administer my elections. I understand that electing benefits to which I or any other person is not entitled is considered fraud and if I willfully misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, benefits will terminate, I must repay any claims which have been paid inappropriately, and I may face dismissal or charges. I understand that the County expects to continue the Program, but it is the County's position that there is no implied contract to do so. I also understand that the County reserves the right at any time and for any reason to amend the Program, subject to the County's collective bargaining agreements. The County may also amend the Program, prospectively or retroactively to comply with applicable law.

⇨ Signature: _____ Date: _____

Return to the OHR Health Insurance Team via email: benefits@montgomerycountymd.gov, or fax: 240-777-5131.